INSTRUCTIONS ON HOW TO COMPLETE THE MEDICAL ASSISTANCE PERSONAL CARE SERVICES APPLICATION AND ASSESSMENT – DHMH 302

I. ASSESSMENT INFORMATION

A. ***Date of Assessment***: Enter date of assessment.

B. ***Indicate if assessment is Initial, Annual or Re-Assessment*** (other than annual, due to change of status i.e., after hospitalization, nursing facility/rehabilitation).

II. APPLICANT INFORMATION

A. ***Applicant's Name***: Enter applicant's name last and first name.

B. ***Address***: Enter complete address.

C. ***Date of Birth***: Enter applicant's date of birth and age.

D. ***Gender***: Enter whether applicant is male or female.

E. ***Applicant's Telephone Number and Medical Assistance (M.A.)#***: Enter applicant's 10-digit telephone number and 11-digit Medical Assistance Number.

F. ***Racial/Origin: Enter applicant's race (check all that apply)*** i.e., **American Indian or Alaska Native** (a person having origins in any of the original peoples or North or South America, including Central America, and who maintains tribal affiliations or community attachment); **Asian** (a person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam); **Black or African American** (a person having origins in any of the black racial groups of Africa); **Native Hawaiian or other Pacific Islander** (a person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands); **White** (a person having origins in any of the original peoples of Europe, the Middle East or North Africa). If necessary, reiterate to applicant that information will be used by authorized Program staff for statistical purposes only.

G. ***Is applicant Hispanic or Latino*** (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin)**?** Check yes or no.

H. ***Primary Language***: Is applicant English speaking? Check **yes** or **no**, if **no** indicate primary language.

I. Indicate if applicant chose not to provide requested information in F., G. and H.

III. SOCIAL INFORMATION

A. ***Marital Status***: Check the marital status of the applicant.

B. ***Check each of the items that apply to the applicant's living arrangement***. Enter additional information in appropriate spaces as necessary. If the applicant resides in an assisted living facility, enter the facility's license number and expiration date and the licensed capacity.

C. ***Responsible Relative/Guardian or Emergency Contact***: Enter the required information in the appropriate spaces.

D. ***Is there any person assisting the applicant with activities of daily living?*** If yes, enter name of person, address, phone number, and relationship to the applicant. Use another sheet to document if more than one person is assisting the applicant.

E. ***Is there any person the applicant recommends as a personal care provider?*** If yes, enter name of person, address, phone number and relationship to the applicant.

F. ***Other services received and frequency***:

1. Check each service that the applicant is currently receiving. After each type of service checked, write the number of times per week or month the service is received by the applicant. Check all the boxes that apply to the applicant. For the Developmental Disabilities Administration (DDA) and Medicaid Waiver Services please indicate the specific Waiver that applies i.e., New Directions (NDW), Living at Home (LAH), and Older Adult (OAW), etc.

2. Enter name(s) of contact person(s) in agency, the name of their agency and telephone number for the services checked. Use additional sheet if needed.

G. ***Has applicant ever been determined eligible for any type of long term institutional care?*** Check the appropriate box.
If the applicant has been determined eligible for long term institutional care, enter the date of determination and the type of care (e.g., chronic hospital, nursing facility).

H. ***Enter specific reasons for applying for personal care services.***
Include the projected termination of any service currently being received by the applicant, if applicable, reasons for the projected termination of service, a brief description of mental and physical status and changes in support system, if appropriate.

IV. FUNCTIONAL STATUS (Cognitive, Mental and Physical)

A. ***Cognitive Status***: Check the appropriate column for applicant's orientation status, telephone utilization, and medication management.

B. ***Mental Health Status***: Check the appropriate column for applicant's mental health, i.e., exhibits lack of motivation, restless behavior, symptoms of depression, lack of interest in activities, aggressive/abusive behavior and causing harm to themselves or others.

C. ***Vital Signs***: Enter information pertaining to the applicant's vital signs (Body Temperature, Height, Weight, Blood Pressure and Respiration).

D. ***Medications***: Enter all prescribed and over the counter medications the applicant is currently taking. Give dose and frequency of each (use additional sheet if needed). Specify injectibles (if any).

E. ***Diet***: Enter any special dietary requirements of the applicant (i.e. no salt, no sugar, vegetarian, etc.).

F. ***Allergies***: Enter types of allergies known.

G. ***Assessment of Activities of Daily Living and Instrumental Activities of Daily Living***

1. Dependency in Activities of Daily Living (ADL)

Check all applicable boxes or fill in spaces as appropriate.
Indicate by check or X if applicant can provide his/her own care in any area. Indicate by check or X if he/she requires assistance. Indicate if a family member assists in applicant's care or if PC aide will assist in applicant's care in the specific area. Indicate frequency of assistance needed from PC aide.

2. Instrumental Activities of Daily Living (IADL)

Check all applicable boxes or fill in spaces as appropriate.
Indicate by check or X if applicant can provide his/her own care in any area. Indicate by check or X if he/she requires assistance. Indicate if a family member assists in applicant's care or if PC aide will assist in applicant's care in the specific area. Indicate frequency of assistance needed from PC aide.

V. WORKPLACE INFORMATION

A. Indicate if applicant is employed full or part-time. Indicate name and location of applicant's employer. Include how many hours and days a week applicant works.

B. Indicate if applicant needs personal care in his/her workplace. List ADLs and IADLs required, and frequency.

C. Indicate if applicant has additional supports available to him/her in the workplace.

VI. MEDICAL INFORMATION

Indicate if applicant is under the care of physician. If yes, enter the required information about the applicant's physician. Indicate applicant's current diagnoses, chronic medical condition(s) and significant past medical history.

VII. REFERRALS TO OTHER SERVICES

Note/list any referrals to other services during time of assessment.

VIII. APPLICANT CERTIFICATION

The applicant or the applicant's representative signs and dates this section of the form. If the applicant can only sign with an X mark, this signature must be witnessed. The Case Monitor may not act as the applicant's representative.

IX. CASE MONITOR'S INFORMATION AND CERTIFICATION

A. ***Case Monitor's Name***: Enter case monitor's name. If case monitor is employed by an agency, enter the name of the agency.

B. ***Jurisdiction***: Enter name of Local Health Department.

C. ***Telephone number***: Enter telephone number of Case Monitor.

D. ***Assessed Level of Service and Frequency***: Case Monitor indicates recommended level of service and frequency required by applicant.

E. ***Case Monitor's Signature***: The Case Monitor signs and dates this section of the form to certify the assessment.

X. ***Authorization of Service: Indicate by check if applicant is approved or disapproved for personal care services. Indicate the level of service and frequency. The Local Health Department Personal Care Services Program Coordinator or Supervisor signs and dates the authorization.***